Anatomical Self-Portraits as Fieldwork: Observations, Improvisations, and Elicitations in the Medical School

KOSKI, Kaisu

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This exposition discusses an artistic research project involving a field trip to a medical school. It introduces part of my postdoctoral project as a case study, discussing photography and video self-portraits as a means for exploring anatomy and clinical skills education. Instead of analysing the resulting artworks, the exposition has a focus on process and methodology: it elaborates on the artistic process and the various roles an artist-researcher can claim at the site of the medical school and in the study outcomes. The exposition also discusses the ways in which this process may engage medical school participants, and how the participants' reflections intertwine with the artistic outcomes.

Introduction

This exposition discusses the process of an artistic research project by presenting a case study from my postdoctoral research. The case study is based on a field trip to Plymouth University Peninsula Schools of Medicine and Dentistry (PCMD) in the UK, and observation of first-year medical students' anatomy and clinical skills education in September and October 2012. I also conducted sixteen open-ended one-hour interviews with medical and dental educators and students. The artistic outcomes of this field trip involve a photo series and a video piece.

In this project, I use ethnographic means, such as participant observation and interviews, as well as visual and performative means, in collecting and reflecting on the data. I discuss these activities as ethnographic fieldwork, as they are, for instance, grounded in first-hand experience of a cultural setting (Atkinson and others 2001: 4). In fact, I consider interviews and observation methods inherent in artistic processes that aim to explore sociocultural settings, or the cultural other, beyond one's own art practice. Such projects can also be called research-through-art (see Frayling 1993). Fieldwork, the heart of ethnographic research practice, can thus be a foundation for artistic practice as well (Inagaki 2010: 75). In addition, a range of projects emerges in which anthropologists (-artists) propose ways to engender ethnographic knowledge through their art practice (Nashima Degarraod 2007). Whereas ethnographic fieldwork has been criticised for its invisibility and the gap between the production and dissemination of ethnographic knowledge (Castañeda 2006: 82), my case study searches for ways to narrow this gap and make the fieldwork more transparent. My artistic work was done in the medical school environment during my stay; I engaged the participants during the creation process and staged parts of the fieldwork as a video performance.

Artists work with medical education in many ways. For instance, the UK-based theatre company Clod Ensemble holds workshops for medical students in subjects such as communication and performance skills. Furthermore, many actors operate as standardised patients in medical schools. However, to bring art projects into the context of academic (medical education) research, a qualitative researcher outside the artistic production is often invited to interpret the data (see de la Croix and others 2011). Although I identify myself as both an artist and an academic researcher, I am not a trained ethnographer. Instead, similar to many artists, I use ethnographic techniques to inform my work, and, simultaneously, my work aims to inform others about my ethnographic experience. I embrace this dual position in order to decrease the distance and interpretative layers from the observed phenomena, and to develop embodied approaches to thinking and performing *with* the data, instead of only talking about it (see

Bleakley 2005). In other words, not only does the data collected inform the aesthetic choices involved (Schneider 2008), I also examine my observations by reliving them (see Nakashima Degarrod 2007). Furthermore, by unpacking the various stages of the field trip and the reliving, the project explores the potential of the *process* to be considered as (the fundamental part of) the research, as an alternative to a focus only on the project outcomes.

The photo series and the video piece introduced in this exposition are not stand-alone outcomes of the research project but belong to a collection of artworks exploring the body in medical education. Previously presented artworks include two video works, an interactive online artwork, and an animation. [1] Each artwork takes a different approach to the body in medical school: for example, appreciating its narrative, ethical, or choreographic qualities. However, only the photo series and the video piece explored in this exposition situate the artist-researcher's body at the core of the work, rendering the outcomes self-portraiture. Furthermore, they are the only site-specific works, created at the site and involving the study environments as scenery. These photos and the video have a parallel aim – to demonstrate the artistic research process when executed in the context of medical education and to open up discussion about medical school anatomy and clinical skills education.

In this exposition, I focus on the four main phases in the fieldwork of my project: (1) observation of anatomy and clinical skills education, (2) improvisation in the empty teaching sites, (3) elicitation of the results of the improvisation by the medical school participants, and (4) composition of a video piece juxtaposing the participants' reflections and the artistic improvisation process. I demonstrate chronologically how these phases engaged with the medical school participants and sites, and how the new artworks emerged at different stages of this process.

Observation of anatomy and clinical skills education

I began my fieldwork by observing 'the natives' of the medical school: the students and the teachers, as well as the artefacts used in education. Anatomy and clinical skills held my interest as they used actual human bodies and various artificial bodies. In clinical skills education, the students learn to manipulate simulated bodies, or the bodies of their peers, before they have contact with an actual patient. In current anatomical education, in turn, the use of cadaver dissection is not self-evident. More and more medical schools, such as PCMD, are exploring alternative ways of teaching anatomy with living human bodies, anatomical models, and simulations only in so-called *living anatomy*. Living anatomy purposefully brings in the human body and a person, typically a volunteer, to introduce the students to the features of the body's surface and natural variations in body structures, so the students become comfortable with the body without embarrassment (Collett and others 2009). Additionally, to teach anatomy various manikins or plastic models of the whole body or a part of it are used to refer to different internal structures and layers of the human body. Although computerised simulators imitate functions of an actual body, this study focuses on the use of analogue models and simulators.

As the students' anonymity was guaranteed, the university Research Ethics Board granted me formal ethics approval to conduct the observations. In addition, the students and teachers were informed about my project and presence in the classrooms. During my observation period, while aiming for a non-invasive presence in the classroom, I positioned myself in different roles depending on the situation. Barone (2008: 486) noted how, in the context of an arts-informed social inquiry, the researcher has the capacity to participate in more than one discourse or manner of being. One can simultaneously be the specialist and layperson, onlooker as well as participant. I followed some of the exercises from the periphery of the classroom, but in several classes I blended in and wandered around observing right next to the different groups of practicing students. In these instances, the students occasionally thought I was evaluating their actions as an educator, and changed their behaviour accordingly. Furthermore,

in some exercises, such as measuring a pulse, I participated, playing the roles of patient and doctor, thus setting myself in the position of the other in many ways.

The most important observations during the classes, for my study and subsequently the artworks, were the various ways to interlace the anatomical models and the human bodies. The anatomy teachers commonly used anatomical models of body parts positioned in relation to their own bodies, such as a model of the pelvic bone structure held in front of the teacher's own pelvis, to allow the students to imagine how the bones would be situated inside the actual body. This juxtaposition enabled the students to form a mental picture of how the various layers are positioned and move in a living human body. On the basis of this observation, the anatomical models in this project were not observed or visualised as independent artefacts, but their meaning was considered in a physical relationship with the human body only. In clinical skills education, in turn, the partial body models, such as the pelvic box and the injection arm simulators, were often staged on a bed or a table as if there were an actual person attached to them. In those instances, a fellow student took a position, behind or next to the anatomical model, and gave voice to it during the exercise. Sometimes the gap between the simulator and the actual body was covered by a blanket to give the impression of continuity between the bodies.

Improvisation with the anatomy models

Conventional ethnographers may return to their home institutions after a period of observation in a foreign culture; in my case, the one-month observation period in my project was followed by series of improvisations and re-enactments at the medical school sites in the absence of the participants. With the term *improvisation*, I am referring to the artistic activity as part of a site-specific method, through which I aim to find visual-performative forms that synthesise the fieldwork observations, and personal presence and experience, in new artistic imageries. I translated the observations through my body, involving not only realistic experiences but also fictive and potential experiences. The improvisation here, in fact, aimed to be a synthesis of the interpretations as ‘this is how I experienced it’ as well as a potential of ‘this is how it could be’ (see Mitchell and Allnutt 2008: 260). Many of my improvisations take the re-enactment of a classroom situation as a starting point. Re-enactment is a body-based method used beyond artistic research projects. It allows dressing up, pretending, and improvising and casting oneself as the protagonist of one’s own research to reanimate the past through physical and psychological experiences (Agnew 2004). However, the staged photos in this project distance themselves from the actual teaching situations and artefacts observed – for instance, by exaggerating and abstracting them, or adding an emotional layer on the otherwise impersonal plastic models.

When I take the stage in the absence of the ‘real’ actors, the medical students and teachers, my aim is to embody their previous and potential choreographies. My activities thus are not re-enactments that aim to replace a particular unique body or search for a lost totality (Allen 2009: 25–26) as historical re-enactments typically do. Furthermore, instead of re-searching merely the situations played out during the classes, my search extends to new forms of dialogue through them. My body appears as the medium that takes the ‘medical choreographies’ as the starting point but embraces their transformation through imaginary and personal dimensions, anchoring the exercise in the anatomy model. To do that, an aesthetic imperative is involved in this activity. As an artist, I have an established way of working and an artistic ‘signature’ that permeate the topic in different ways than in a written academic description. This signature functions as a backdrop during the dive into the unexpected, creating some of the parameters for assessing the results.

I had private access to the Life Sciences Resource Centre during three weekends in October 2012. The site is the main anatomy education environment for first-year medical students in Plymouth. No students

or staff members were present, and I was allowed freely to photograph the anatomical models and the environments. Improvising on-site is a crucial part of my method: moving through the empty locations and exploring the plastic models without a clear artistic agenda, while at the same time drawing from what I have seen the students and teachers doing during the classes, gives a glimpse of the self-study that each medical student is expected to conduct. It thus includes subliminal role-plays, in which I try to re-enact the students' tasks from previous classes, such as the abdominal thrust manoeuvre for an upper airway obstruction model (Fig. 1), or when I play doctor with a child-like naivety, wear a medical costume, and arrange my plastic patients around the 'hospital' to stimulate potential narratives.

Fig. 1. Re-enacting the clinical skills CPR lessons.

Most models and simulators represent nobody and everybody simultaneously: they don't refer to one person, but all of us are in some ways (supposed to be) represented by them for the medical students. Nevertheless, there are also simulators with a 'personality' and a name, such as the clinical skills models Resusci Anne and Choking Charlie. Furthermore, they are designed to perform actions, since the models must be saved in different ways. As a physical snapshot, they freeze 'a situation' in time, literally being stuck in their expression, a situation that must be solved by the medical student. Although their situations from a medical point of view are similar, their facial expressions are very different. Charlie has an expression of disgust, with closed eyes and an open mouth. A little ball hangs from a thread that can be placed in his mouth and pushed out by squeezing him tightly. Anne's face, in turn, has been compared to that of the Mona Lisa: she has an enigmatic half smile. There are various myths about the origin of the model for Anne. According to one story, she was an unidentified young woman who tragically drowned in the river Seine. Yet another story claims that she had to be a professional actor because it would have been very difficult to maintain such a peaceful expression during the cast-making otherwise (Grange 2013). With her reference to actual people, Resusci Anne is like a *statue*: a once-living thing whose life has been interrupted (Gross 1992: 15). Curiously, Anne not only allows us to project stories of her life but is also created in order to reanimate life back into her body.

The improvisation is characterised by the search for a visual form that can be constructed in either a photograph or a video. In this search, there are three main elements: the body of the artist-researcher, the camera, and the anatomical model. These improvisation sessions were physically intensive in the need to control the camera, the lights, the props, and the (naked) body. I invited the anatomy models to 'talk' to me by setting my body in various positions and relationships to them. Although the models in everyday life represent a silent and passive medium (Arlander 2011), their 'voice' here appears through a child-like play in which they invite me to explore them. For instance, a half-open torso shell 'asks' to be fitted the same way a handprint on a tile would stimulate ideas of pressing one's own hand against it. Moreover, the models function as mirrors to my existing desires and fears, or the impulses rising from the physicality, privacy, and excitement of the situation. This silent dialogue includes visual memories from the anatomy classes, while the situation is guided by the physicality of the models and my own body. However, not all interactions require manipulation of the models' position or pose: I began the improvisation by observing how the models were positioned in the empty classrooms. This resulted in the discovery of the X-ray–like shadow that one skeleton projected onto the wall in the afternoon sun. The feet were unclear in the shadow because of the metal support system, giving me an idea to combine my feet with the shadow of the skeleton.

I explored the visual and kinetic characteristics of the anatomical models, such as how they move and sound. I was trying out what the model could do and what could be done with it, such as rotating its limbs and checking the body parts that could be removed or added. I also began to compare my body with those of the models – an activity I would have felt awkward executing in the presence of the medical school participants. The comparisons easily cause a feeling of being abnormal, or simply totally dissociated from the models, as the norm seems to be a rather tall male body. Additionally, I observed the light sources, reflections, and different surfaces available at the site. Once I found a visual form to work with, the 'form perfectioning' phase began. This was characterised by the repetition of the photo-composition until all the elements were portrayed in the desired way (Fig. 2). Here the site-specificity of the project created constraints: I could not take the photo later at my own studio without the anatomy models.

Fig. 2. Improvisations with a skeleton.

Improvisation in this project takes place behind and before the camera. I am creating test set-ups with anatomy models and photographing them; simultaneously, I video record these activities from a distance. Although in the space there is no dialogical partner that would participate in or direct my actions, the video camera functions as the *sensed* other (see Peters 2009: 99), rendering my actions performative. Furthermore, when I move between, behind, and in front of the camera, I actually switch between the roles of inventing and performing the action, and assessing it as a spectator. The improvisation sessions were not intended to be live performances: I preserved my seclusion to explore freely and arrive at new ideas. Nevertheless, I did partly feel observed as in a performance situation. There was a heightened awareness arising not only from the mild creepiness of being 'stared' at by empty eye sockets and artificial eyeballs: although the classrooms were empty, many have large glass walls to the hallway. There was also the possibility that someone might have seen my activities and even entered the room, thereby witnessing a half-naked woman, previously introduced as a visiting

postdoctoral fellow, dragging and dismantling the anatomical models. Although this never happened, because of the partial privacy and the time pressure the work was more charged than it would have been in my own studio.

The photo series *Living Anatomy*: the artist's body in research

The photo series *Living Anatomy* (2013) resulted from my improvised exploration of anatomy education and the various anatomical models representing aspects of the body in relation to the living body. *Fidelity* (Fig. 3.) is an oft-used term when talking about simulation, where it refers to the degree to which the model body simulates the actual human body. The photo juxtaposes four different representations of the human head: the bone structure, the muscles and tendons, the living anatomy head/patient, and Resusci Anne. The photo portrays the difficulty of taking the actual human body as a parameter for the models' fidelity, as the bodies are all different. In the practice of medicine, one might, in fact, turn the situation around and observe the patient and *his or her* fidelity to the normality of the anatomical model.

Fig. 3. *Fidelity* (2013), 200 × 41 cm, digital C-print, Diasec mount.

Behind my Inside (Fig. 4.) visualises the common situation of a living body behind a skeletal model in anatomy education. However, the living body in this photo is wearing a medical costume, and putting visible effort into simulating the position and the size of the skeleton, instead of allowing a difference in size and shape. *Canvass* (Fig. 5.), in turn, contains a dual reference to a medical examination and the white canvas that fills the image. The work is inspired by the deconstruction of the body into different layers, in relation to the actual examination situation. It refers to the continuums between the various body types applied in anatomy education, as the students are asked to fill these gaps in their minds.

Fig. 4. *Behind my Inside* (2013), 55 × 80 cm, digital C-print, Diasec mount.

Fig. 5. *Canvass* (2013), 55 × 80 cm, digital C-print, Diasec mount.

Puppeteer (Fig. 6) is a close-up of the living body behind a skeleton, exploring the particular movement qualities of the model. These movements obviously differ from those of the living body, because the skeleton's limbs are not supported by muscles and other tissues. The limbs of a skeleton may thus turn unnaturally or stay attached to one another. Not all the images involve direct anatomy study material: In *Standardized Body* (Fig.7), I use a found artefact: an abandoned plastic shell of the torso model from an anatomy classroom corner. The image portrays the exploration of the parameters of normality and health conducted in anatomy studies, a mould within which the normal bodies fit. The shell's function is mostly decorative, but it also creates the body shape around the organs, which are the actual learning materials. The torso has two covering plastic panels, the front and the back of the body, which can be

detached from each other. The front panel (of a male model) appears to simulate my torso size; or, alternatively, my body happens to simulate this standard body for learning anatomy.

Fig. 6. *Puppeteer* (2013), 65 × 60 cm, digital C-print, Diasec mount.

Fig. 7. *Standardized Body* (2013), 65 × 60 cm, digital C-print, Diasec mount.

Although the inanimate bodies used in medical education are not intended for artistic performances, their educational uses involve performativity. Regarding these interactions with a human agent, their

characteristics can be compared to performing objects such as puppets and masks. The distance between the performer and the performing object has been considered one of the key factors in determining the dynamics within (Kaplin 1999). In most of the classroom situations, as well as in my photos, the human body operates either right behind or next to the artificial body, since no technology is used to bridge a larger distance. For instance, I am standing right behind the skeleton and moving its arms analogously to mine, and lining up my head within a range of medical 'masks'. However, I also alter these proximities by going inside the torso shell and, in fact, thereby simulate the anatomical model myself. Actually, the shell is alienated from the actual body twice – (as if) it is a cast of an artificial body. Furthermore, the shell is a transparent mask, a sculptural expression imposed from without (Kaplin 1999: 33), which, in this case, displays a colourless non-expression exposing the body inside in a fixed contour. Still, the term *distance* has a meaning beyond the physical proximity between performing object and performer, appearing as a separation between an object and its image (ibid.: 34). I employ this separation in the photo *Canvass*, and frame out the skeleton that is the source of the shadow to create a continuum between the performer and the shadow of the performing object. In this analogue, the photo frame functions as a puppet stage preserving the secret of puppetry.

Though the photos could quite literally be called autophotography – that is, I photograph myself – autophotography as a research method conventionally refers to a situation in which the research *participant* is given a camera and invited to photograph either him- or herself or his or her surroundings, often to study self-concept or identity (Ziller 1990). Though I chose to title this exposition with a reference to self-portraits, this label also seems inadequate to describe my images. While beyond their research context they can be perceived as self-portraits of some kind, the photos do not primarily aim to portray me as a person, or to study my identity, for instance. Instead, my presence draws from performance art, in which the artist uses herself as material and the artist's body thus becomes the medium of communication (Arlander 2013). From another frame of reference the ambivalent presence in the images is similar to that of a living anatomy model in the medical school anatomy class, whose role exists in the intersection of being and acting, simultaneously performing the self and not self (Collett and others 2009: 95–96). However, I am also introducing a certain theatrical code. In three of the five photos in the series, I am actually unidentifiable as I purposefully position myself behind an anatomical model or a screen. Furthermore, in three photos I wear a medical costume, and even portray an emotion. From a theatrical perspective, the photos could, in fact, be read as 'performed photography', performances staged solely to be photographed without existing as autonomous events for audiences (Auslander 2006: 2).

Despite this, the images do not study me, I am present in them in more ways than only physically or aesthetically. The images echo my ambivalence toward what I have witnessed in medical school: there is the terror of becoming yet another model in the continuum toward absolute fidelity, or being read as an anatomical model with low fidelity to a *normal* body. Even though I feel uneasy being evaluated according to such categories, I recognise a wish to conform to the standard. My facial expression, when not hidden, projects this discomfort. Nevertheless, this in itself does not distinguish my body from those of the models: for instance, Choking Charlie also has a suffering expression. Instead of generating new facial expressions for anatomy models, I thus wish to expand the spectrum of medical educational bodies by choreographic and scenographic means through superimposing body layers and types, and creating in-between bodies, such as shadows. Furthermore, I introduce the dimension of time, and visualise it through a long shutter speed, as a means of differentiating the inanimate models and the animate human body. Yet paradoxically, the photograph as a medium treats these bodies equally by *arresting* time for both (see Barthes 1981).

It seems crucial to me that I used my own presence in the images, instead of hiring an actor, for instance. The primary reason is that improvisation as executed here is a fundamental element of my way of working as an artist. Furthermore, to ask someone to step in from outside is likely to lead the improvisation to directions away from those I have witnessed during my observations. Moreover, being

merely behind the camera would seem inadequate and leave a sense of being yet again an observer, as during the classes. To fully explore and translate ideas that emerged through the participants' observation, my own body seems to be a necessary instrument, as does my own eye at the camera. Additionally, using my own body is, in this instance, free from many ethical and financial consequences. I do not have to ask for permission to portray a person identifiably or to look for a budget to hire an actor.

Photo elicitation: participants diagnosing the photo *Canvass*

Photo elicitation is a method of inserting photographs in an interview with the aim of evoking dimensions in human consciousness beyond words, thus leading to new views in the participants (Harper 2002). In this project, I use photo elicitation to continue the interaction with the participants, allowing them to reflect on my interpretation of their field. This way my art practice is seen through the eyes of medical educators and students. As I had already begun my photo improvisations in the anatomy classrooms by the time I conducted my interviews, I printed out two of the photo sketches and showed them to the participants during the interviews. One photo is *Canvass*, which later became part of the *Living Anatomy* series. In an interview setting, the participants were asked what they saw in the image – what came to their minds spontaneously when looking at it. *Canvass*, which presents a pair of feet in sandals behind a medical screen, is at first glance not an unfamiliar sight in medicine; however, due to the dated look of the curtain, and the closeness, direction, and distance of the feet from each other, the situation appears slightly off, unnatural, and strange. I considered this an interesting starting point for a photo elicitation. It is suggested that, to elicit useful interviews, the images used should 'break the frame' of the participants' normal views (Harper 2002: 20). The origin of the photo was kept from the participants. I revealed only afterwards that it was made by me.

I distinguished four main aspects in the participants' interpretations: an analytical reading from a clinical point of view, emotional associations from a personal perspective, questions or descriptions of the artistic process behind the image, and interpretations involving cultural viewpoints such as regulated eye contact in the doctor–patient relationship. The clinical professionals commonly reflected the image through experiences in their practice, whether anorexia in paediatrics, or a wish to use a blanket around the patient to provide privacy in general practice.

Clinical interpretation:

The majority of the participants included clinical interpretations in their elicitation, focusing on the feet behind the curtain. They typically made interpretations about the sex, age, and ethnicity of the feet's owner, but occasionally included a potential diagnosis related to viewing the image and its meanings as a whole.

> Participant 1: 'It appears that the person could be female, possibly young to middle-aged.'

> Participant 2: 'Looks as if it is a Caucasian female…'

> Participant 3: 'I can see the pelvis, I can see the ribs…'

Participant 4: ‘I kind of took it as an image of body distortion. Although you classically expect that as a representation in the mirror rather than other people seeing them as a skeleton.’

Cultural interpretation:
These comments point toward the cultural meanings seen in the photo. The screen as an element of a physical examination was brought to focus, stimulating thoughts about the cultural need for privacy or eye contact in the doctor–patient relationship.

Participant 5: ‘Unless there was a specific cultural need, it would be desirable to have eye contact with your patient.’

Participant 6: ‘I suppose there are cultural differences. British people are generally quite shy.’

Emotional/personal interpretation:
Here the participants express their personal preferences for using a screen in clinical practice. The word *barrier* is negatively charged in this context, as well as being associated with *hospital*. Participants also wondered about the emotional motives and status of the person behind the screen, acknowledging the odd position of the feet.

Participant 7: ‘You can see a curtain, a barrier. Is it a person who does not want to come and reveal herself?’

Participant 8: ‘I don’t like curtains. They remind me of . . . what’s the word . . . *hospital*. But I’m interested in the shoes because that reminds me there’s a person.’

Participant 9: ‘She’s quite shy and apprehensive. It just seems quite vulnerable.’

Aesthetic/meta interpretation:
The interpretations in this category acknowledged the staged status of the photo. For instance, participants wondered how the shadow was created on the screen, and evaluated the illusion of the continuity from the feet to the skeleton’s shadow.

Participant 10: ‘How is this made, the picture? I thought you had the light behind the screen.’

Participant 11: ‘I have to say, I think the feet are too small for the skeleton.’

Participant 12: ‘It’s interesting how the light . . . It’s an interesting piece of art.’

Participant 13: ‘I can’t see the rest. If there is a rest.’

The video piece *Canvass mise-en-scene*

The fourth stage of the process in this study was the composition of a new video piece, which accompanies the *Living Anatomy* photo series. *Canvass mise-en-scene* (2014) is a four-minute video piece, which portrays, as the title suggests, the process of preparing the set for the photo *Canvass*. It is a one-shot piece, in which the camera stays in the frontal position from which the photo *Canvass* was taken. In front of the camera, I stage the medical curtains, change into a medical costume behind the curtain, and bring in the skeleton to cast a shadow on the curtain. I take time to position the skeleton so that it produces the desired shadow, thus supporting the appearance of an improvisation, and subsequently take a position behind the curtain as the pair of sandals in the photo.

The soundtrack of the video piece includes the participants’ earlier associations collected through the photo elicitation. By presenting the image and inviting the participants’ interpretations of it, I have actually imitated the diagnostic task of a medical or dental professional when the patient presents a clinical ‘mystery’. [2] Moreover, in the video piece the participants simultaneously diagnose their own practice, cultural features embedded in medicine, and the artwork and the artist creating the piece. With this video piece, I juxtapose the meanings the medical and dental school participants have given to the photo *Canvass* with the process of me composing the photo.

VIDEO LINK: http://www.kaisukoski.com/about/living-anatomy/canvass-mise-en-scene

Through the staged nature of the images and my presence in them, the photographs and video are in this project characterised by performativity. *Canvass mise-en-scene* can, in fact, be seen as a performance. It represents a form of theatrical performance documentation, as the act of documenting my process as a performance constitutes its status as a performance (Auslander 2006). In this regard, the camera’s presence simulates a member of the audience, and I am aware of it while executing my actions. Nevertheless, one can wonder whether the activity recorded actually counts as improvisation, as I have thought of the actions executed beforehand. In fact, the video is recorded in the form-perfectioning stage of my process, in which I have decided a set of actions and do several runs to get the best shot. Some of the actions I execute are unnecessary in terms of the set building: changing into the operating room costume behind the curtain, for instance, is not necessary for the photo to be taken. Instead, as a performance, I go through a transformation process, which aims to simulate the natives of this environment, the medical professionals. From a cinematic viewpoint, the video is in many ways authentic and transparent. I break the frame of the image in several ways – for instance, by moving in and out of the image and checking the camera image every now and then by looking into the preview monitor. However, I also use montage and thus construct the piece to support its status as a video. To make the narrative more compact and complement the participants’ comments, the piece uses editing techniques to show the entire build up process of the set quicker than in real life. Moreover, the positioning of the curtains in the beginning is viewed by cross-fading still images, and the changing of clothes is speeded up.

Reflections

This article elaborates on the process of fieldwork in an artistic research project in medical education. It distinguishes four main phases of the case study project, which results in performative photo and video works. Although presented in this exposition as a logical process, as if the stages were planned beforehand, my fieldwork methodology emerged primarily during my stay at the medical school, according to possibilities that revealed themselves only on the spot. This improvisatory quality characterises many ethnographic field trips (Cerwonka and Malkki 2007) though, and is not related to my inexperience with ethnographic methods, for instance.

During this field trip, improvisation as an artistic technique intentionally played a large role. I wished to incorporate the site-specific dimension in the resulting artworks, and to create an immediate and reflective space for the observations. This artistic departure from the medical school observations can be inspiring, but it also raises questions. How does one, for instance, preserve the connection between and generate relevance for the emerging imageries regarding the actual observations? Or are they even self-evident goals? The artworks addressed in this exposition emerge from the exploration of the artist-researcher's body as a research medium. This exposition thus proposes that not only the findings generated during a fieldtrip but also a methodological interest may be the impetus for the resulting artworks.

The new understandings produced in this case study project especially concern the repertoire of roles an artist-researcher may possess in the field, which is related to her physical presence in the artistic outcomes of the project. Similarly, the relationship between the representations of the self/author and the other/participant is at the core of ethnographic reflection. In this project, I take on that relationship with the self-portraits created in the medical school. The use of the artistic-researcher's own body (images) in the research on the cultural *other* naturally raises questions such as who is the other/participant in this project? Perhaps, depending on the situation, it is the medical student or teacher, me, or the artificial other: the anatomy model. In the video piece, for example, I set the participants in the position of an ethnographic observer, and myself as an object of the ethnographic gaze (see Atkinson and Hammarsley 1994: 256).

Some suggest that ethnographers should surrender to the other and the culture they wish to study (Wolff 1964), instead of observing it from a distance. Although the word *surrender* resonates in many ways with my experience in medical schools, it also evokes resistance. I have surrendered to the medical school culture in my project in a physical-metaphorical sense, such as when I squeeze my body into a plastic model or wear an unnecessary medical costume. Furthermore, I have allowed myself to become fond of many participants and greatly admire them. Nevertheless, I have preserved my artistic fidelity by remaining loyal to my imagination and intuition, allowing them to infiltrate the activities and the outcomes. Seen from another perspective, perhaps witnessing 'how doctors are made' does not advance one's will to surrender to a medical treatment. Although a comforting curtain of mystification had previously supplemented my trust in medical science, seeing the 'backstage' has definitely emphasised the human factor and the certain arbitrariness that is involved. For instance, the initial CPR lesson with the simulators was very casual and quick, compared to what I had expected, and to me the first-year students looked very young. I found myself wondering whether this was really how they were supposed to learn all these 'medical manoeuvres'. Still, at the end of a three-year postdoctoral project into medical education, I also notice involuntary changes in my thinking. Sitting in on countless medical school classes has not been innocent, but it has altered my views on the body and health. Although I may have naively surrendered to the experience, it has occasionally triggered a clash of cultures in my personal experience. I have not been converted to a native in the medical field, but my previous beliefs about what it means to be and have a body have been infiltrated by the gentle brainwashing of medical ways of seeing and talking about the body. As an artist, I explore this dissonance gratefully.

[1] These artworks can be viewed at www.kaisukoski.com.

[2] I note elsewhere (Koski 2013) how medical students commonly view the body and its symptoms as a mystery they should solve.

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